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benefit-by-benefit comparison of the proposed plan to one or more of the three other benchmark plans specified above or to the State's standard full Medicaid coverage package), and of the population to which coverage will be offered. In addition, the State should submit any other information that will be relevant to a determination that the proposed health benefits coverage will be appropriate for the proposed population.

(2) [Reserved]

§ 440.335 Benchmark-equivalent health benefits coverage.

- (a) Aggregate actuarial value. Benchmark-equivalent coverage is health benefits coverage that has an aggregate actuarial value, as determined under §440.340, that is at least actuarially equivalent to the coverage under one of the benchmark benefit packages described in §440.330 for the identified Medicaid population to which it will be offered.
- (b) Required coverage. Benchmarkequivalent health benefits coverage must include coverage for the following categories of services:
- (1) Inpatient and outpatient hospital services.
- (2) Physicians' surgical and medical services.
 - (3) Laboratory and x-ray services.
- (4) Well-baby and well-child care, including age-appropriate immunizations
 - (5) Emergency services.
- (6) Family planning services and supplies and other appropriate preventive services, as designated by the Secretary.
- (c) Additional coverage. (1) In addition to the categories of services of this section, benchmark-equivalent coverage may include coverage for any additional services in a category included in the benchmark plan or described in section 1905(a) of the Act.
- (2) If the benchmark coverage package used by the State for purposes of comparison in establishing the aggregate actuarial value of the benchmark-equivalent package includes any of the following four categories of services: Prescription drugs; mental health services; vision services; and hearing services; then the actuarial value of the coverage for each of these categories of service in the benchmark-equivalent coverage package must be at least 75 percent of the actuarial value of the

coverage for that category of service in the benchmark plan used for comparison by the State.

(3) If the benchmark coverage package does not cover one of the four categories of services in paragraph (c)(2) of this section, then the benchmark-equivalent coverage package may, but is not required to, include coverage for that category of service.

EFFECTIVE DATE NOTE: At 78 FR 42306, July 15, 2013, \$440.335 was amended by adding paragraphs (b)(7)and (8); revising paragraph (c)(1); and removing paragraph (c)(3), effective Jan. 1, 2014. For the convenience of the user, the added and revised text is set forth as follows:

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- (b) * * *
- (7) Prescription drugs.
- (8) Mental health benefits.
- (c) * * *
- (1) In addition to the types of benefits of this section, benchmark-equivalent coverage may include coverage for any additional benefits of the type which are covered in 1 or more of the standard benchmark coverage packages described in §440.330(a) through (c) or State plan benefits, described in section 1905(a), 1915(i), 1915(j), 1915(k) and 1945 of the Act, any other Medicaid State plan benefits enacted under title XIX, or benefits available under base-benchmark plans described in 45 CFR 156.100.

§ 440.340 Actuarial report for benchmark-equivalent coverage.

- (a) A State plan amendment that would provide for benchmark-equivalent health benefits coverage described in §440.335, must include an actuarial report. The actuarial report must contain an actuarial opinion that the benchmark-equivalent health benefits coverage meets the actuarial requirements set forth in §440.335. The report must also specify the benchmark coverage used for comparison.
- (b) The actuarial report must state that it was prepared according to the following requirements:
- (1) By an individual who is a member of the American Academy of Actuaries (AAA).